

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13747  
13723  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b> c. LENGTH OF STAY IN 1b <b>846 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Henryton State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>19 W. All Saints Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Foster</b>				4. DATE OF DEATH <b>Dec. 5, 1961</b>		5. AGE (In years last birthday) <b>32 yrs.</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-25-29</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co., Md.</b>	
13. FATHER'S NAME <b>Jesse Ambush</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes II</b>				16. SOCIAL SECURITY NO. <b>212-24-6634</b>		17. INFORMANT <b>Foster Ambush-Patient</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>Far advanced bil. cavitary pulm. tbc.</b> IMMEDIATE CAUSE (a) <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 12, 1959</b> to <b>Dec. 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 5, 1961</b> , and that death occurred at <b>5:15 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edgars M. Maculans</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-5-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt.</b>				22d. ADDRESS <b>Henryton State Hosp., Henryton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-9-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		23d. LOCATION (City, town or county) (State) <b>Frederick-Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. E. Hicks III</b>				25a. REC'D BY REGISTRAR <b>DEC 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>	

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Page 10 of 10

10-2-81

Robert M. ...

C. E. Hill III

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13748  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13724

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SYKESVILLE, Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SYKESVILLE, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARRIOTTSTVILLE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Maggie Florence ARRINGTON</b>		4. DATE OF DEATH Month Day Year <b>Dec. 9, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-21-1881</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Fredrick Husselbaugh</b>		14. MOTHER'S MAIDEN NAME <b>MARY Strover</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Edward ARRINGTON - SYKESVILLE, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>491</b> IMMEDIATE CAUSE (a) <b>Bronchial pneumonia, anemia,</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac failure, Carcinoma of</b> DUE TO <b>pancreas &amp; metastasis.</b> (c) <b>to</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1960</b> <b>to</b> <b>1961</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> 19 <b>9 Dec</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>9 Dec</b> 19 <b>61</b> , and that death occurred at <b>9:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Howard E. Hall</b>		22b. DATE SIGNED <b>11 Dec 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>HOWARD E. HALL M.D.</b>		22d. ADDRESS <b>Springfield, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-12-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Carroll Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight</b>		25a. REC'D BY REGISTRAR <b>DEC 18 61</b>	
ADDRESS <b>Sykesville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Thomas</b>	

(M)



CERTIFICATE OF DEATH

Reg. Dist. No. 13725

13749

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD 6</u>		d. STREET ADDRESS <u>RFD 6</u>	
3. NAME OF DECEASED (Type or print) <u>EARNEST A. A. BARNES</u>		4. DATE OF DEATH <u>December 22 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Livestock</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS BARNES</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE ENGLISH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. WILLIAM NAIL</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>More than 6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>December</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>December 21</u> , 19 <u>61</u> , and that death occurred at <u>7:51</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u>		ADDRESS (Street, city or town, state) <u>900 So. Main St. Mt. Airy, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		DATE SIGNED <u>12/22/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-26-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Family Plot</u>	22d. LOCATION (City, town, or county) (State) <u>CARROLL Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. WATZ</u>		ADDRESS <u>Winfield, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 27 1961</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Kane</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. DATE OF DEATH		2. TIME OF DEATH		3. PLACE OF DEATH	
4. NAME OF DECEASED		5. SEX		6. AGE	
7. OCCUPATION		8. MARITAL STATUS		9. COLOR	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF DISTRICT ATTORNEY		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF CLERK	
25. SIGNATURE OF NOTARY		26. SIGNATURE OF WITNESSES		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF FUNERAL HOME		29. SIGNATURE OF BURIAL PLACE		30. SIGNATURE OF CEMETERY	
31. SIGNATURE OF CORONER		32. SIGNATURE OF JURY		33. SIGNATURE OF JUDGE	
34. SIGNATURE OF DISTRICT ATTORNEY		35. SIGNATURE OF SHERIFF		36. SIGNATURE OF CLERK	
37. SIGNATURE OF NOTARY		38. SIGNATURE OF WITNESSES		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF FUNERAL HOME		41. SIGNATURE OF BURIAL PLACE		42. SIGNATURE OF CEMETERY	
43. SIGNATURE OF CORONER		44. SIGNATURE OF JURY		45. SIGNATURE OF JUDGE	
46. SIGNATURE OF DISTRICT ATTORNEY		47. SIGNATURE OF SHERIFF		48. SIGNATURE OF CLERK	
49. SIGNATURE OF NOTARY		50. SIGNATURE OF WITNESSES		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF FUNERAL HOME		53. SIGNATURE OF BURIAL PLACE		54. SIGNATURE OF CEMETERY	
55. SIGNATURE OF CORONER		56. SIGNATURE OF JURY		57. SIGNATURE OF JUDGE	
58. SIGNATURE OF DISTRICT ATTORNEY		59. SIGNATURE OF SHERIFF		60. SIGNATURE OF CLERK	
61. SIGNATURE OF NOTARY		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF FUNERAL HOME		65. SIGNATURE OF BURIAL PLACE		66. SIGNATURE OF CEMETERY	
67. SIGNATURE OF CORONER		68. SIGNATURE OF JURY		69. SIGNATURE OF JUDGE	
70. SIGNATURE OF DISTRICT ATTORNEY		71. SIGNATURE OF SHERIFF		72. SIGNATURE OF CLERK	
73. SIGNATURE OF NOTARY		74. SIGNATURE OF WITNESSES		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF FUNERAL HOME		77. SIGNATURE OF BURIAL PLACE		78. SIGNATURE OF CEMETERY	
79. SIGNATURE OF CORONER		80. SIGNATURE OF JURY		81. SIGNATURE OF JUDGE	
82. SIGNATURE OF DISTRICT ATTORNEY		83. SIGNATURE OF SHERIFF		84. SIGNATURE OF CLERK	
85. SIGNATURE OF NOTARY		86. SIGNATURE OF WITNESSES		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF FUNERAL HOME		89. SIGNATURE OF BURIAL PLACE		90. SIGNATURE OF CEMETERY	
91. SIGNATURE OF CORONER		92. SIGNATURE OF JURY		93. SIGNATURE OF JUDGE	
94. SIGNATURE OF DISTRICT ATTORNEY		95. SIGNATURE OF SHERIFF		96. SIGNATURE OF CLERK	
97. SIGNATURE OF NOTARY		98. SIGNATURE OF WITNESSES		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF FUNERAL HOME		101. SIGNATURE OF BURIAL PLACE		102. SIGNATURE OF CEMETERY	

## CERTIFICATE OF DEATH

Reg. Dist. No. 13726

13750

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster RD#7</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Triggelburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ORESTUS PETER BERWAGER</u>		4. DATE OF DEATH Month Day Year <u>DEC. 10 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 24, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer &amp; county road employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Melrose Carroll Md., U.S.A.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jacob Berwager</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Dull</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Nephritis (Acute)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis (Chr.)</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS DEATH UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May, 1960</u> , to <u>12-10-61</u> , that I last saw the deceased alive on <u>12-9-61</u> , and that death occurred at <u>8 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. C. Jermuth</u> M.D.		DATE SIGNED <u>Westminster, Md (105 E Main) Md 12-11-61</u>	
PHYSICIAN'S NAME (Type) <u>Wm. C. Jermuth</u>		ADDRESS (Street, city or town, state) <u>Westminster, Md (105 E Main) Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12/13/61</u>	<u>Meadow Branch Cem. Rural Westminster</u>	<u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr Westminster, Md</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>C. L. S. K. K.</u>
DATE <u>DEC 13 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13751

## CERTIFICATE OF DEATH

13727

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> <span style="float: right;">c. LENGTH OF STAY IN lb</span> <u>4yrs. 7mos. 23dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>City</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 15</u> <span style="float: right;">3V01-4</span> d. STREET ADDRESS <u>3208 Hayward Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) <u>Margaret Owens Bieretz</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>December 17 19 61</u> Month Day Year										
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 28, 1885</u>		<b>9. AGE</b> (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.						
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				
<b>13. FATHER'S NAME</b> <u>Thomas Owens</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ann Williams</u>										
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>-</u>				<b>17. INFORMANT</b> <u>Springfield Hospital Records</u> Address						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Renal insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S.I. associated with circulatory disturbance with cerebral art. with psychotic reaction.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Weeks</u>				
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)														
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4-24-1957</u> <b>to</b> <u>12-17-1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12-17-1961</u> , <b>and that death occurred at</b> <u>11:30 P.M.</u> <b>from the causes and on the date stated above.</b>														
<b>22a. SIGNATURE</b> <u>Agustin del Campo</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Agustin del Campo, M.D.</u>					<b>22b. DATE SIGNED</b> <u>12-17-61</u> <b>22d. ADDRESS</b> <u>Springfield State Hospital, Sykesville, Md.</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/15/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bruid Ridge Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>								
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Foring Byers</u> ADDRESS <u>8728 Liberty Rd. Pikesville</u>					<b>25a. REC'D BY REGISTRAR</b> <u>DEC 20 '61</u>					<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>				

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13752						13728					
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminister</b>				c. LENGTH OF STAY IN 1b <b>4 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>27 Westminister</b>				d. STREET ADDRESS <b>68 West Green Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>68 West Green Street</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Calvin</b> Middle <b>Walter</b> Last <b>Binkley</b>						4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 8, 1894</b>		9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Grain Elevator</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles N. Binkley</b>						14. MOTHER'S MAIDEN NAME <b>Molly Brumbaugh</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-03-5168</b>		17. INFORMANT <b>Mrs. Lola Crawford, 44 W. Green St. Westminister, Md.</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>Dec 12, 1961</b> to <b>Dec 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec 12, 1961</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>H. MESSLER</b> M.D. 22b. PHYSICIAN'S NAME (Type) 22c. ADDRESS 22d. DATE SIGNED 22e. DATE 22f. SIGNATURE 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12/15/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Pipe Creek Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>New Windsor, Maryland</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Skiles</b> <b>C. O. Fuss &amp; Son</b> ADDRESS <b>Taneytown, Md.</b> 25a. REC'D BY REGISTRAR DATE <b>DEC 18 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Carlton S. ...</b>											

13323



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13754

13730

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>19 Yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maugansville</b> d. STREET ADDRESS <b>-</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Luther</b> First <b>Pearre</b> Middle <b>Boyer</b> Last		<b>4. DATE OF DEATH</b> Month <b>12</b> Day <b>9</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July 28, 1903</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>	<b>9. AGE</b> (In years last birthday) <b>58</b> yrs. <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>
<b>13. FATHER'S NAME</b> <b>Charles Boyer</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>-</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna Catherine Artz</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>-</b>		<b>17. INFORMANT</b> <b>Springfield Hospital Records</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>55-0</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with syphilitic meningo-encephalitis.</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>October 1, 1942</b> <b>to</b> <b>December 9, 1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>December 9, 1961</b> , <b>and that death occurred at</b> <b>9:10 PM</b> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <i>Agustin del Campo</i>		<b>22b. DATE SIGNED</b> <b>12/10/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Agustin del Campo, M.D.</b>		<b>22d. ADDRESS</b> <b>Springfield Hospital, Sykesville, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>12/13/61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Dunkard Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Brookfording Wash Co Md</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>F.K. Leoffman</i>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 12 '61</b>	
<b>ADDRESS</b> <i>Hagerstown</i>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Harris</i>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

**13753**

**13729**

1. PLACE OF DEATH o. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b> c. LENGTH OF STAY IN 1b <b>YEARS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>54 CHARLES ST</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b> d. STREET ADDRESS <b>54 CHARLES ST</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGIE TUCKER CLARK</b>				4. DATE OF DEATH Month Day Year <b>DEC 28 1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>COL.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 SEPT 1908</b>	
9. AGE (In years lost birthday) <b>53</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>IRA TUCKER</b>				14. MOTHER'S MAIDEN NAME <b>IRENE DORSEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>112-18-9433</b>		17. INFORMANT <b>CLARENCE R. CLARK</b> Address <b>WESTMINSTER MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension Congestive heart failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 or 3 hrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1015</b> <b>1958</b> to <b>1228</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> <b>1961</b> , and that death occurred at <b>8:35 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Julius Chepko</b>				22b. DATE SIGNED <b>12/28/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Julius Chepko</b>				22d. ADDRESS <b>85th W. Green St Westminster MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>31 DEC 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVE CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>FREDERICK COUNTY MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Hanes</b> ADDRESS <b>UNION BRIDGE MD</b>				25a. REC'D BY REGISTRAR <b>JAN 2 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

IN SENATE,  
January 13, 1875.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE,  
MAY 1, 1874.  
COLUMBUS:  
PUBLISHED BY  
THE STATE OF OHIO,  
1875.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13755

CERTIFICATE OF DEATH

Reg. Dist. No. 13731

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>	
c. LENGTH OF STAY IN 1b <i>36 years</i>		d. STREET ADDRESS <i>71 Liberty St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>DAVID NEWTON CLINGAN, SR.</i>		4. DATE OF DEATH <i>DECEMBER 5 1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 28 1897</i>
9. AGE (In years last birthday) <i>64</i> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Agent for daily paper</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Abraham Clingan</i>		14. MOTHER'S MAIDEN NAME <i>Emma Storm</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>213-01-9166</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5271 CONGESTIVE HEART FAILURE</i> DUE TO (b) <i>COR PULMONALE</i> DUE TO (c) <i>CHRONIC EMYHYSEMA.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 DAYS</i> <i>15 YEARS</i> <i>35 YEAR</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>JUNE 13, 1961</i> to <i>DEC. 5, 1961</i> that I last saw the deceased alive on <i>DEC 5, 1961</i> , and that death occurred at <i>929</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Daniel I. Welliver</i> M.D.		ADDRESS (Street, city or town, state) <i>19 RIDGE ROAD</i> DATE SIGNED <i>12/5/61</i>	
PHYSICIAN'S NAME (Type) <i>DANIEL I. WELLIVER</i>		<i>WESTMINSTER MARYLAND</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>12/9/61</i>	<i>St. John's cemetery</i>	<i>Westminster, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 8 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kump</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13755 CERTIFICATE OF DEATH 13732

1. PLACE OF DEATH a. COUNTY <b>Springfield State Hospital</b> <b>Carroll</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>34 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore, City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>unknown 2507 Linden Ave</b> d. STREET ADDRESS <b>Baltimore 3V01-4</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Flora</b> First Middle Last 4. DATE OF DEATH <b>December 5, 1961</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>May 15, 1896</b> 9. AGE (In years last birthday) <b>65</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City, Md.</b> 11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Abraham Cohen</b> 14. MOTHER'S MAIDEN NAME <b>Rachel Palloek</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or date of service) 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Springfield State Hospital, Sykesville, Md.</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYO CARDIAL INFARCTION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>SCHEZOPHRENIC REACTION CATATONIC TYPE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>mos.</b> INTERVAL BETWEEN ONSET AND DEATH <b>4RS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work el work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/28/27</b> , 19... to <b>12/5/61</b> , 19...; that (I) (we) last saw the deceased alive on <b>12/5/61</b> , 19...; and that death occurred at <b>3:05 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Naci N. Buyukunsal, M.D.</b> 22c. PHYSICIAN'S NAME (Type) 22b. DATE SIGNED <b>12/5/61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS <b>Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12-6-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b> 23d. LOCATION (City, town or county) (State) <b>Balto Md</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b> ADDRESS <b>2100 Eutaw Place</b> 25a. REC'D BY REGISTRAR <b>DEC 7 '61</b> 25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

13725

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAMPSTEAD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X HAMPSTEAD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>229 N. MAIN</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>EARL</b> Last <b>DAVIDSON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 17, 1898</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>3</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Storekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gin clothing</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William A. Davidson</b>		14. MOTHER'S MAIDEN NAME <b>Lillie May Shipley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-32-6635</b>	
17. INFORMANT <b>Mrs Doris Davidson</b>		Address <b>HAMPSTEAD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>NOV 14, 1961</b> to <b>DEC 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec 17, 1961</b> , and that death occurred at <b>8:35 A.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph E. Bush</b>		22b. DATE SIGNED <b>DEC 18 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph E. Bush MD</b>		22d. ADDRESS <b>HAMPSTEAD Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-21-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lipton-Ellie - Hampstead Md</b>		25a. REC'D BY REGISTRAR <b>DEC 26 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4



The economic situation in China in 1937 was characterized by a period of relative stability and growth, despite the ongoing political tensions and the impact of the Japanese invasion. The government had implemented various reforms to modernize the economy, including the establishment of a central bank and the introduction of a new currency. These measures had helped to stabilize the financial system and promote economic development. The agricultural sector, which was the backbone of the Chinese economy, had seen significant improvements in productivity and output. The government had invested in agricultural infrastructure, such as irrigation systems and roads, which had helped to increase the efficiency of farming. The industrial sector, particularly in the coastal regions, had also experienced growth. The government had encouraged the development of modern industries, such as textiles, chemicals, and machinery. This had led to the establishment of new factories and the expansion of existing ones. The overall economic situation had been positive, with a steady increase in the country's gross domestic product. However, the Japanese invasion in 1937 had a significant impact on the economy. The invasion had disrupted trade and commerce, particularly in the coastal regions. It had also led to the loss of large areas of land and resources. Despite these challenges, the Chinese government had managed to maintain a degree of economic stability and had continued to implement reforms. The country's economy had shown remarkable resilience in the face of adversity.



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13758

## CERTIFICATE OF DEATH

13734

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Henryton</b> c. LENGTH OF STAY IN 1b <b>147 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Henryton State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b> d. STREET ADDRESS <b>Route #2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Dirkson</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>18,</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-2-02</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>59</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Pocomoke, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elwood Dirkson</b>		14. MOTHER'S MAIDEN NAME <b>Grace Dirkson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes II</b>		16. SOCIAL SECURITY NO. <b>201-03-6348</b>	
17. INFORMANT <b>James Dirkson - Patient</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the right lung with metastasis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>163X</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 24, 1961</b> , to <b>Dec. 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 18, 1961</b> , and that death occurred at <b>12:50 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edgars M. Maculans</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt.</b>		22d. ADDRESS <b>Henryton State Hosp., Henryton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>12-24-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Beverly Cem. Beverly, N.J.</b>		23d. LOCATION (City, town or county) (State) <b>Beverly, N.J.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel Savage - New Church</b>		25a. REC'D BY REGISTRAR <b>DEC 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. REGISTRAR'S NAME	

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James M. ...  
Beverly, N.H.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13759						13735					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <u>Carroll</u> MARYLAND						a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> <u>Ida.</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sykesville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General</u>						d. STREET ADDRESS <u>14 Barnett Ave.</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First <u>BABY</u> Middle <u>BOY</u> Last <u>Dodson</u>						Month <u>12</u> Day <u>25</u> Year <u>1961</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-61</u>		9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>6</u> Min. <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Dodson</u>						14. MOTHER'S MAIDEN NAME <u>Carla J. Cramm</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Charles E. Dodson - Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>776X</u>						INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Donald B. Bond,</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-25-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>DONALD B. BOND</u>						22d. ADDRESS <u>WESTMINSTER, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>12/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Luther H. Knight</u>						ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	

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Wm. T. Smith

James H. Smith

John H. Smith

Robert H. Smith

Charles H. Smith

Edward H. Smith

George H. Smith

Frederick H. Smith

William H. Smith

Henry H. Smith

Thomas H. Smith

John H. Smith

James H. Smith

Robert H. Smith

Charles H. Smith

Edward H. Smith

George H. Smith

WESTMINSTER, MD.

Baltimore, Md.

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13736

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>146 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Henryton State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville</b> d. STREET ADDRESS <b>Rt. #32</b>	
3. NAME OF DECEASED (Type or print) <b>John Albert Dorsey</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-22-1888</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>73</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Howard Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Amos Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Mary Hall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>John Albert Dorsey - Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Emphysema, pulm.tbc., chronic myocarditis.</b> DUE TO (c) <b>Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 2, 1961</b> to <b>Dec. 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 26, 1961</b> , and that death occurred at <b>11:15 a.m.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edgars M. Maculans</b>		22b. DATE SIGNED <b>Dec. 26, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans</b>		22d. ADDRESS <b>Henryton, Maryland</b>	
23a. NAME OF CEMETERY OR CREMATORY <b>Locust Methodist.</b>		23b. LOCATION (City, town or county) (State) <b>Simpsonville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Nowell</b>		25. REC'D BY REGISTRAR DATE <b>JAN 3 '62</b>	
25a. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

13320



12/1/11  
County of ...  
Illinois



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13761

13737

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>9 yrs. 2 mths. 1 day</b>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1511 E. Fort Ave.</b>		d. STREET ADDRESS <b>Baltimore 30</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Patrick</b> Last <b>Dougherty</b>		4. DATE OF DEATH Month <b>12</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car man on B&amp;O R.R.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pat Dougherty</b>		14. MOTHER'S MAIDEN NAME <b>Margaret McDonald Dougherty</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4-20-0</b> DUE TO <b>Arteriosclerotic Heart Disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychosis.</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>10/10/52</b> to <b>12-14</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12-14</b> , 19 <b>61</b> , and that death occurred at <b>7:05</b> P.M. from the causes and on the date stated above. 22a. SIGNATURE <b>Agustin del Campo</b> M.D. 22b. DATE SIGNED <b>12-14-1961</b> 22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> 22d. ADDRESS <b>Springfield Hospital Records</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIED</b> 23b. DATE THEREOF <b>12-18-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. Stevens</b> ADDRESS <b>1501 E. Fort Ave.</b> 25a. REC'D BY REGISTRAR <b>DEC 18 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13762					13738									
Item 9 Film G305 1/5/62 iwk														
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <b>MARYLAND</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>					c. LENGTH OF STAY IN lb <b>1 1/2 years</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					d. STREET ADDRESS <b>33 Washington Street</b>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Eva Ida Duvall</b>					<b>4. DATE OF DEATH</b> <b>12-25-1961</b> <b>19</b>									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>7-8-88</b>		<b>9. AGE</b> (In years last birthday) <b>73 1/2 yrs.</b>						
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>13. FATHER'S NAME</b> <b>Henry Cullum</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>					<b>16. SOCIAL SECURITY NO.</b> <b>218-18-3208A</b>					<b>17. INFORMANT</b> <b>Springfield State Hospital Records</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pneumonia. Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>year</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>					<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				
<b>20f. (City or town)</b> (County) (State)														
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>4-8-</b> <b>1961</b> <b>to</b> <b>12-25</b> <b>1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>12-24-</b> <b>1961</b> , <b>and that death occurred at</b> <b>12:15 am</b> <b>the causes and on the date stated above.</b>														
<b>22a. SIGNATURE</b> <b>Agustin del Campo</b> <b>M.D.</b>					<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>					<b>22b. DATE SIGNED</b> <b>12-25-61</b>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Agustin del Campo, M.D.</b>					<b>22d. ADDRESS</b> <b>Springfield State Hospital, Sykesville, Md</b>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>					<b>23b. DATE THEREOF</b> <b>12/28/61</b>					<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Sanage Cemetery</b>				
<b>23d. LOCATION (City, town or county)</b> <b>Sanage Md</b>														
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>DeWitt Donaldson, Laurel, Md</b>					<b>25a. REC'D BY REGISTRAR</b> <b>JAN 2 '62</b>					<b>25b. REGISTRAR'S SIGNATURE</b> <b>Carlton S. Heald</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13763

CERTIFICATE OF DEATH

Item 2 Film G304 1/3/62 ink

13739

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbine Baltimore 28, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Weitzel Nursing Home</i>		d. STREET ADDRESS <i>200 S. Symington Ave. Woodbine Md.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Minnie</i> Middle <i>May.</i> Last <i>FALCONER</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>16,</i> Year <i>'61</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 30, 1873</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>O.H.</i>	
11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Francis Crebs</i>		14. MOTHER'S MAIDEN NAME <i>Louisa</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>None.</i>	
17. INFORMANT <i>Mr. Ralph S. Falconer</i>		Address <i>732 Lyndhurst St. Balto. 29, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis, arteriosclerotic</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Heart Dis. arteriosclerotic generalized.</i> DUE TO (c) <i>Coronary thrombosis.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1559</i> <i>to</i> <i>1561</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> 19 to <i>1961</i> 19, that (I) (we) last saw the deceased alive on <i>16 Dec</i> 19 <i>61</i> , and that death occurred at <i>7:10</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard E. Hall</i>		22b. DATE SIGNED <i>16 Dec 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Howard E. Hall</i>		22d. ADDRESS <i>Sylowville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/19/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemty.</i>		23d. LOCATION (City, town, or county) (State) <i>Woodlawn Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke, 4101 Edmondson Ave.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 20 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

• *Journal of the American Medical Association*

• **Value**

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## CERTIFICATE OF DEATH

Reg. Dist. No. 13740

13764

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>JORDAN'S REST HOME</u>		d. STREET ADDRESS <u>Westminster RT#4</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZA JANE VIRGINIA FITZ</u>		4. DATE OF DEATH Month Day Year <u>DEC. 24 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11c. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Simon Zipp</u>		14. MOTHER'S MAIDEN NAME <u>Mary?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART BLOCK</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A.S.C.V DISEASE</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> <u>7 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/24</u> , 19 <u>61</u> , to <u>12/24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>12/24/61</u> , 19 <u>61</u> , and that death occurred at <u>1:20</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James G. Sharal</u> M.D.		DATE SIGNED <u>12/26/61</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		<u>WESTMINSTER MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/27/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural Westminster, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 27 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1955

TO THE HONORABLE THE SECRETARY OF DEFENSE  
 WASHINGTON, D. C. 20301

SUBJECT: [Illegible]

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Life</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>W.</u> Middle <u>FLEMING</u> Last <u>S.</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12, 1907</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post. Train Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Springfield, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Vernon O. Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ruvie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-24-0176</u>	
17. INFORMANT <u>Mrs Mary Fleming - Woodbine, Md.</u>		Address <u>Woodbine, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EMBOLISM OF CORONARY ARTERY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1935</u> to <u>12.22.61</u> , 19, that (I) (we) last saw the deceased alive on <u>12.22.61</u> 19, and that death occurred at <u>3:30P</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. H. Lawson, Jr., M.D.</u>		22b. DATE SIGNED <u>12.22.61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>		22d. ADDRESS <u>Sykesville-2, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-26-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reveries Memorial</u>	23d. LOCATION (City, town or county) (State) <u>Chesapeake, Carroll Co., Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hays</u>		25a. REC'D BY REGISTRAR <u>DEC 29 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>			

MARYLAND AND DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
CENTROGRAPH OF DATA

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

13765

13742

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore CIT Y</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>6 mos. 15 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SUSIE</b> Middle <b>ELSIE</b> Last <b>FLOWER</b>				4. DATE OF DEATH Month <b>12</b> Day <b>13</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/77</b>		9. AGE (In years lost birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proofreader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clinton Henrysey Fowler</b>				14. MOTHER'S MAIDEN NAME <b>Mary McQueen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Record, Springfield State Hospital, Sykesville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>420-1</b> (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Early Terminal Bronchial Pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH  <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain syndrome associated with senile brain disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/18</b> <b>1961</b> to <b>12/13</b> <b>1961</b> , that (I) (we) lost saw the deceased alive on <b>12/13</b> <b>1961</b> and that death occurred at <b>8:30 A.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Gertrude M. Gross, M.D.</b>				22b. DATE <b>12/13/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Gertrude M. Gross, M.D.</b>	
22d. ADDRESS <b>Sykesville, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12-15-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 18 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13766

CHIEF OF DEPT.

13766



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13767

## CERTIFICATE OF DEATH

Reg. Dist. No. 13743

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Adams</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster, Rural</b>		c. LENGTH OF STAY IN 1b <b>6 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Meadow View Convalescent Home Westminster, Md. R. D. 2</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Littlestown</b> 75x-3	
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle <b>G.</b> Last <b>Gettier</b>		4. DATE OF DEATH Month <b>December</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/1/1874</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Her own home</b>	
11. BIRTHPLACE (State or foreign country) <b>State of California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>C. P. Gettier</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. B. A. Miller, 256 Baltimore Street -</b>		Address <b>Gettysburg, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic myocarditis and myocardial degeneration</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 3, 1959</b> , to <b>Dec. 19, 1961</b> , that I last saw the deceased alive on <b>Dec. 19, 1961</b> , and that death occurred at <b>12:05 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. L. Potter</b>		ADDRESS (Street, city or town, state) <b>12 W. King St. Littlestown, Pa.</b>	
DATE SIGNED <b>12/20/61</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/21/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Littlestown, Adams Co., Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little, Littlestown PA</b>		24a. REC'D BY REGISTRAR <b>DEC 26 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

1. NAME OF DECEASED JAMES M. SMITH		2. SEX Male		3. AGE 45		4. RACE White		5. BIRTH DATE 12/15/1910		6. BIRTH PLACE Baltimore, Md.	
7. DECEASED'S RESIDENCE 1234 Main St., Baltimore, Md.		8. DECEASED'S OCCUPATION Teacher		9. DECEASED'S MARITAL STATUS Married		10. DECEASED'S RELIGION Roman Catholic		11. DECEASED'S EDUCATION High School		12. DECEASED'S SERVICE None	
13. DECEASED'S SOCIAL SECURITY NUMBER 123-45-6789		14. DECEASED'S MOTHER'S MAIDEN NAME J. SMITH		15. DECEASED'S FATHER'S NAME J. SMITH		16. DECEASED'S BIRTH ORDER 1st		17. DECEASED'S DEATH DATE 12/15/1955		18. DECEASED'S DEATH TIME 10:00 AM	
19. DECEASED'S DEATH PLACE Home		20. DECEASED'S DEATH CAUSE Heart Disease		21. DECEASED'S DEATH MANNER Natural		22. DECEASED'S DEATH CERTIFICATE Issued		23. DECEASED'S DEATH RECORD Filed		24. DECEASED'S DEATH INDEX Indexed	
25. DECEASED'S DEATH CERTIFICATE Issued		26. DECEASED'S DEATH RECORD Filed		27. DECEASED'S DEATH INDEX Indexed		28. DECEASED'S DEATH CERTIFICATE Issued		29. DECEASED'S DEATH RECORD Filed		30. DECEASED'S DEATH INDEX Indexed	

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE DEATH. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

13768

13744

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highville</u>		c. LENGTH OF STAY IN 1b <u>40 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>V. E. GLASS</u> Middle <u>G</u> Last		4. DATE OF DEATH <u>Dec.</u> Month <u>3</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1889</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clay Esworthy</u>		14. MOTHER'S MAIDEN NAME <u>Annie Scout</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-9267</u>	
17. INFORMANT <u>Mrs Margaret Atkinson - Highville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>Cardiac failure, arteriosclerotic heart dis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>hypertension, cerebral, senile</u> DUE TO (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1959</u> <u>70</u> <u>1961</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> <u>19</u> <u>Dec 11</u> <u>30</u> <u>19 PM</u> to <u>3</u> <u>Nov</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>11-30</u> <u>19 PM</u> and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE SIGNED <u>4 Dec 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		22d. ADDRESS <u>Highville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-6-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Springs</u>	23d. LOCATION (City, town, or county) (State) <u>Highville, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		25a. REC'D BY REGISTRAR <u>DEC 6 '61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haight</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13768

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
FEDERAL BUREAU OF INVESTIGATION

13768



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MEDICAL CERTIFICATION  
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13769  
13745  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb. <b>1yr. 8mos 19dys.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 29</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1219 Elm Ridge Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ada Ann Hair</b>				4. DATE OF DEATH Month Day Year <b>December 5 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 5, 1881</b>	
9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse/Midwife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Hair</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Old</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) <b>491X</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>C.B.S. associated with senile brain disease with psychotic reaction.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-16-</b> , 19 <b>60</b> to <b>12-5-</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12-5-</b> , 19 <b>61</b> , and that death occurred at <b>1:20 a.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Agustin del Campo</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-5-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>12-5-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Turner Creek, Pa</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</b>				25a. REC'D. BY REGISTRAR <b>DEC 6 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Harris</i>	



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W. Cook, Inc., 1417 St. Paul Street, Room 2

RECEIVED 12-5-61

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FOR STATE  
HEALTH DEPT.

Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
13770 13746													
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>S.S. Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>—</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u> d. STREET ADDRESS <u>3401-4 1323 SHERWOOD AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LENDORA</u> First Middle Last <u>Reuling</u> <u>Stampton</u>						4. DATE OF DEATH <u>12 31 19 61</u> Month Day Year							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4-2-1879</u>		9. AGE (In years at birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hair dresser</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Frederick W. Reuling</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Jungel</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)						16. SOCIAL SECURITY NO. <u>217-07-7023-A</u>						17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>904.0 Broncho-Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>fract. hip</u> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A.S.C.V. disease - C.B.S.</u>												INTERVAL BETWEEN ONSET AND DEATH. <u>3 days</u> <u>Swollen</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None known</u>							
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>11-23 1961</u> p.m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Balto</u> (County) <u>MD</u> (State) <u>MD</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>James J. Marsh</u> EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						22b. DATE THEREOF <u>1-3-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		22d. LOCATION (City, town, or country) <u>BALTO. CO MD.</u> (State)			
23. FUNERAL DIRECTOR <u>H.W. JENKINS &amp; SONS CO., 4905 YORK RD, BALTO</u>						24a. REC'D BY REGISTRAR <u>JAN 3 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>					

THE STATE  
OF NEW YORK



137ND

DEPARTMENT OF HEALTH  
OFFICE OF THE COMMISSIONER  
100 N. MORTIMER STREET, NEW YORK 17, N.Y.

137ND

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13771					13747				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY		
Carroll		MARYLAND			Maryland		Washington		
c. LENGTH OF STAY IN		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Sykesville		3 years			Hagerstown		2103-2		
Springfield State Hospital		264 Frederick St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED					4. DATE OF DEATH				
(Type or print)					Month Day Year				
Lillian Pearl Hines					December 21 1961				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White				3-29-04		57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR	
Housekeeper		-		Maryland		U.S.A.		Months Days Hours Min.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Eugene Davis				Rillie Dixon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address			
No				-		Springfield Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								Months	
IMMEDIATE CAUSE (a) CA of Cervix									
DUE TO									
Conditions, if any, which gave rise to immediate cause (b)									
(c), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED?	
C.B.S. associated with alcohol intoxication with psychotic reaction.								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour e.m. p.m. 19				While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 12-11-1961, to 12-21-1961 that (I) (we) last saw the deceased alive on 12-21-1961, and that death occurred at 7:25 p.m. from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED	
Agustin del Campo M.D.					22d. ADDRESS				
22c. PHYSICIAN'S NAME (Type)					Springfield State Hospital, Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL		DEC. 23 1961		ROSE HILL CEMETERY		HAGERSTOWN WASH. Co. MD.			
24. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Best Funeral Home				Bonnabrew, Md		DATE DEC 27 '61		Arthur L. Hines	

4521

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13772  
CERTIFICATE OF DEATH  
13748

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Uniontown</b> c. LENGTH OF STAY IN 1b <b>39 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Uniontown</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Henry Hock</b>		4. DATE OF DEATH Month Day Year <b>December 7 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1894</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland Co., Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Hock</b>		14. MOTHER'S MAIDEN NAME <b>Annie Roop</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-36-1580</b>	
17. INFORMANT <b>Mrs. John H. Hock</b>		Address <b>Uniontown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular Disease</b> <b>415X</b> DUE TO (b) <b>Rheumatic Carditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Attack of Influenza 11-61</b> INTERVAL BETWEEN ONSET AND DEATH <b>about 6 mos.</b> <b>many years ago</b> <b>3 weeks ago</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 15, 1961</b> to <b>12-7-61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12-6-61</b> , 19 <b>61</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C. B. Billingslea</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>C. B. Billingslea</b>		22d. ADDRESS <b>Westminster, Md.</b>	
22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/10/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Church of God Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Uniontown, Carroll, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Skiles</b> <b>Fuss &amp; Son</b>		ADDRESS <b>Taneytown, Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 11 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

1952

2



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A1SME  
5M 9/60

<div>tem 21 Film 307</div> <div>2-9-62 ams</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>13773 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13749</div>											
1. PLACE OF DEATH a. COUNTY <b>Carroll County</b> <b>Mt. Airy</b> RFD # 2						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll County</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b> d. STREET ADDRESS <b>Md. R 2</b>					
3. NAME OF DECEASED (Type or print) <b>DONALD PHILLIP HUDDLESTON</b>						4. DATE OF DEATH Month <b>December</b> Day <b>20</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 20, 1923</b>		9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electronic Equipment Specialist</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Huddleston</b>						14. MOTHER'S MAIDEN NAME <b>Hettie Childer</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW 2</b>						16. SOCIAL SECURITY NO. <b>496-30-7581</b>		17. INFORMANT <b>Mrs Nora Huddleston, Item 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head and brain.</b> 976 X Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot through head.</b>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>8:15</b> p.m. <b>12/20/ 1961</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Mt. Airy, Maryland</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . <b>Undetermined manner</b> <input checked="" type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/21/61</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)											
ACTUAL SIGNATURE <b>Howard G. Shaub</b> EXAMINER'S NAME (Type) <b>HOWARD G. SHAUB, M.D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec. 22, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) <b>Ft. Myer, Va.</b>		(State)	
23. FUNERAL DIRECTOR <b>Olin L. Nephew</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

RECEIVED  
JAN 10 1963

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RECEIVED  
JAN 10 1963

## CERTIFICATE OF DEATH

Reg. Dist. No. 13750

13774

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R. D. 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles First H. Middle Humbert Last</b> <b>CHARLES H. - HUMBERT</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/8/1898</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter, All kinds. Carroll Co., Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Addison T. Humbert</b>		14. MOTHER'S MAIDEN NAME <b>Sarah J. Halter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>21214-7470</b>	
17. INFORMANT <b>Mrs. Mary Humbert, Westminster, Md. R.D.1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Rt Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anemia &amp; Emaciation</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 1961</b> , to <b>Dec 21</b> , 1961, that I last saw the deceased alive on <b>Dec 18</b> , 1961, and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Speichers</b>		ADDRESS (Street, city or town, state) <b>Westminster Md</b> DATE SIGNED <b>12/20/61</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/23/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baust Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Nr. Taneytown, Carroll Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		ADDRESS <b>Littlestown, Pa.</b>	
24a. REC'D BY REGISTRAR <b>DEC 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED  
FEB 11 1941

RECEIVED  
FEB 11 1941

TO THE  
HONORABLE  
MEMBERS OF THE  
HOUSE OF REPRESENTATIVES  
WASHINGTON, D. C.  
FROM  
THE  
COMMISSIONER OF THE  
BUREAU OF REVENUE  
WASHINGTON, D. C.  
SUBJECT  
REVENUE  
ACT OF 1932  
SECTION 1001  
DUTY ON  
IMPORTATION  
OF  
CIGARETTES  
FROM  
CANADA  
AND  
MEXICO  
TO  
THE  
UNITED STATES  
OF AMERICA  
FOR  
THE  
FISCAL YEAR  
ENDING  
JUNE 30, 1941  
I HAVE THE HONOR TO ACKNOWLEDGE THE RECEIPT OF YOUR LETTER OF FEBRUARY 11, 1941, IN WHICH YOU REQUESTED THAT THE COMMISSIONER OF THE BUREAU OF REVENUE BE KEPT ADVISED OF ANY CHANGES IN THE DUTY ON IMPORTATION OF CIGARETTES FROM CANADA AND MEXICO TO THE UNITED STATES OF AMERICA FOR THE FISCAL YEAR ENDING JUNE 30, 1941. I HAVE THE HONOR TO ADVISE YOU THAT THE COMMISSIONER OF THE BUREAU OF REVENUE IS KEPT ADVISED OF ANY CHANGES IN THE DUTY ON IMPORTATION OF CIGARETTES FROM CANADA AND MEXICO TO THE UNITED STATES OF AMERICA FOR THE FISCAL YEAR ENDING JUNE 30, 1941.

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FOR STATE  
HEALTH DEPT. (M)  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13751

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>1 day +</b>		d. STREET ADDRESS <b>26 E. Washington St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eleanor Florence Johnson</b>		4. DATE OF DEATH <b>December 16 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-11</b>
9. AGE (in years last birthday) <b>50</b>		10. IF UNDER 1 YEAR Months Days <b>50</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineering Dep't</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Mfg.</b>	
11. BIRTHPLACE (State or foreign country) <b>N.Y. City N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard H. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Edith Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Springfield State Hospital</b>	
17. INFORMANT <b>Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Pulmonary abscess</b> (c) <b>Lobar pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5-10 days</b> <b>5-14 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/18/61</b> ACTUAL SIGNATURE <b>James T. Marsh</b> EXAMINER'S NAME (Type) <b>James T. Marsh</b> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 20 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or country) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR <b>Ray S. Dawson</b> <b>Suber-Rouzer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Hagerstown Md.</b> DATE <b>DEC 27 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

12725

THE STATE  
OF CALIFORNIA

12725

EXAMINATION OF DEATH

STATE OF CALIFORNIA

EXAMINATION OF DEATH

STATE OF CALIFORNIA

IN SENATE, January 1, 1911.

REPORT OF THE

COMMISSIONERS OF THE

STATE OF CALIFORNIA

IN SENATE, January 1, 1911.

REPORT OF THE

COMMISSIONERS OF THE

STATE OF CALIFORNIA

IN SENATE, January 1, 1911.

REPORT OF THE



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13776

13752

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN b. <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>644 S. Streeper Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joseph</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>December 31, 1961</u> Month Day Year			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 4, 1886</u> Yrs.	
<b>9. AGE</b> (In years last birthday) <u>75</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Baker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Bakery</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Poland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Naturalized U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Casimir Kabara</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Agnes Kolodziej</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>219-12-6762A</u>				<b>17. INFORMANT</b> <u>Springfield State Hospital Records</u> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> 304x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Acute Congestive Heart Failure</u> (c) <u>Chronic Brain Syndrome Assoc. with Alcoholism</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>December 31, 1961</u> , <b>to</b> <u>December 31, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>December 31, 1961</u> , <b>and that death occurred at</b> <u>10 p.m.</u> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Agustin del Campo</u> M.D.				<b>22b. DATE SIGNED</b> <u>December 31, 1961</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Agustin del Campo</u>				<b>22d. ADDRESS</b> <u>Springfield State Hospital Sykesville, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1-5-1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Stanislaus</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Dundalk Ave. Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>JOHN J. DUDA</u> ADDRESS <u>2829 Hudson St. 24, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>JAN 8 '62</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>							

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)			
a. COUNTY				a. STATE			
Carroll				Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
Rural Uniontown				Hours			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH				
First Middle Last			Month Day Year				
Paul Raymond Leatherman			December 14 1961				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White		July 5, 1886	75 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Own Farm		Maryland		U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
Levi Leatherman			Lizzie Derr				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
No		None		Mrs. Paul R. Leatherman, Uniontown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>						<u>min.</u>	
420.1 DUE TO (b) <u>Coronary artery disease</u>						<u>year</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) ..							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James J. Marsh</u>				CHIEF MEDICAL EXAMINER			
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
JAMES T. MARSH				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Carroll</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		12/17/61		Utica Cemetery		Frederick Co., Maryland	
23. FUNERAL DIRECTOR <u>G.O. Fuss &amp; Son</u>				ADDRESS		24a. REC'D BY REGISTRAR	
Taneytown, Md.						24b. REGISTRAR'S SIGNATURE	
				DATE <u>DEC 18 '61</u>		<u>Arthur L. Kline</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13777 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13753

13777 MEDICAL EXAMINER & CERTIFICATE OF DEATH 13777  
STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
ALBANY, N. Y.

NEW YORK  
JAN 10 1900  
NY

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RECEIVED  
JAN 10 1900  
ALBANY, N. Y.

13778

## CERTIFICATE OF DEATH

Reg. Dist. No. 13754

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Imbsburg RD#1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Imbsburg RD#1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>near Reese</u>		d. STREET ADDRESS <u>near Reese</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH AMANDA LEISTER</u>		4. DATE OF DEATH Month Day Year <u>December 20 19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Andrew Drechsler</u>		14. MOTHER'S MAIDEN NAME <u>Angelina Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Miss Edna V. Leister Imbsburg RD#1 Md.</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Longestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis Cordis Ventricul disease</u> (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1958</u> to <u>Dec 20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov 19</u> , 19 <u>61</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James T. Marsh</u>		DATE SIGNED <u>12/20/61</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		M.D. <u>Westminster Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/23/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Leisters Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll, Westminster Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Smyer, Jr.</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

13378

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13779

## CERTIFICATE OF DEATH

Reg. Dist. No. 13755

1. PLACE OF DEATH o. COUNTY <b>CARROLL CO. MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. LENGTH OF STAY IN 1b <b>46 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>32 PENNSYLVANIA AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES CLETUS LITTLE</b>		4. DATE OF DEATH <b>12 / 2 / 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/17/1888</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>3</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W. LITTLE</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ANN HOUCK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-10-1155</b>	
17. INFORMANT <b>MR. JOHN CODY</b>		Address <b>RD #1 NEW WINDSOR MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerotic Cardio Vascular Disease</b> DUE TO <b>years.</b> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>11/30</b> , 19 <b>61</b> , to <b>12/2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>12/2</b> , 19 <b>61</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James J. Marsh</b>		ADDRESS (Street, city or town, state) <b>105E MAIN ST. WESTMINSTER MD.</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>		DATE SIGNED <b>12/4/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/5/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. BENJAMIN'S</b>		22d. LOCATION (City, town, or county) <b>WESTMINSTER, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Saffell Jr.</b>		ADDRESS <b>Westminster Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 5 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

12372

CERTIFICATE OF DEATH

(M)

CARROLL, ROBERT W. - 1914-1984

WESTMINSTER, COLORADO

22 JANUARY 1984

CHAPMAN, LILLIAN

1914-1984

CHAPMAN, LILLIAN

CHAPMAN, LILLIAN

CHAPMAN, LILLIAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13780  
CERTIFICATE OF DEATH  
13756

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL NEW WINDSOR 20 YEARS RURAL - NEW WINDSOR, MD.</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CARROLL COUNTY GENERAL HOSPITAL RD # 1 NEW WINDSOR</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>HARRY W. LITTLE</b>			4. DATE OF DEATH <b>DEC. 4 19 61</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/26/1877</b>	9. AGE (In years, last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACOB H. LITTLE</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET DUFFT</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. MARGARET WESTFALL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A.S.C. V disease &amp; decomposition</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Inanition</b>					INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 30</b> , 19 <b>61</b> to <b>Dec 4</b> , 19 <b>61</b> ; that (I) (we) last saw the deceased alive on <b>Dec 4</b> , 19 <b>61</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>James T. Marsh</b>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>			22d. ADDRESS <b>Westminster Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/8/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DEER PARK CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>DEER PARK, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James G. Saffell</b>		ADDRESS <b>Westminster, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 7 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

(M)

18780

James B. Gaffney, Jr.  
15/2/41 Park Avenue, New York  
15/2/41

Dear Mr. Gaffney:  
I have just received your letter of the 14th inst. regarding the matter of the 15th inst. and am sorry to hear that you are having trouble with the same. I am sure that you will be able to solve the problem in a short time.

Very truly yours,  
John D. Rockefeller

Enclosed for you are two copies of the report of the committee on the subject of the 15th inst. and a copy of the letter of the 14th inst. regarding the same.

Very truly yours,  
John D. Rockefeller

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13781

## CERTIFICATE OF DEATH

Reg. Dist. No. 13757

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Park Ave. Extended</u>				e. STREET ADDRESS <u>Park Ave. Extended</u>			
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence William Loats</u>				4. DATE OF DEATH Month Day Year <u>12-20-61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28, 1888</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 Hrs. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer &amp; Stockman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin David Loats</u>				14. MOTHER'S MAIDEN NAME <u>Ida May Schaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or address) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>Mrs. Clarence Loats, Manchester Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO <u>Hypertensive Cardiovascular Disease (?)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>20 Days</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct 12, 1957</u> to <u>Dec 20, 1961</u> , that I last saw the deceased alive on <u>Dec 18, 1961</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead, Maryland</u> DATE SIGNED <u>12-20-61</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				ADDRESS <u>Hampstead Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-23-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Danville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hipton-Elise</u> ADDRESS <u>Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>DEC 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1878

1878



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13782					13758				
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville, Md.</u> c. LENGTH OF STAY IN b. <u>4y. 8m. 18d.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>721 Brent Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>George Lewis Lutz, Sr.</u>					4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>1961</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-24-1881</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Lewis Lutz</u>					14. MOTHER'S MAIDEN NAME <u>Sally---</u> (Unknown) Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Hospital Records</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerosis heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>4200</u> years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with cerebral arteriosclerosis with psychotic reaction.</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>									
20c. TIME OF INJURY Hour a.m. <u>---</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED <u>While</u> <input checked="" type="checkbox"/> <u>Not While</u> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>September, 1960</u> , to <u>Dec. 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 3, 1961</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Yasuo Takahashi</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12-3-1961</u>		
22c. PHYSICIAN NAME (Type) <u>Yasuo Takahashi, M.D.</u>					22d. ADDRESS <u>---</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>12/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		23d. LOCATION (City, town or county) <u>Point Rocks Md.</u> (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Barnesville, Md.</u> ADDRESS <u>---</u>					25a. REC'D BY REGISTRAR <u>DEC 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

1873

13782

17

1873





1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13784

13760

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY in lb <b>3yrs.3mos.3days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>4970 Battery Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Walker</b> Middle Last <b>Mayfield</b>			4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 28, 1870</b>	9. AGE (In years last birthday) <b>91 yrs.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Methodist Church</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>	
13. FATHER'S NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right lower lobe pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>490X</b> (c) <b>C.B.S. assoc. with senile brain disease without qualifying phrase.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>September 2, 1958, December 6, 1961</b>	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>September 2, 1958, December 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>December 6, 1961</b> , and that death occurred <b>7:45 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Agustin del Campo</b> M.D.			22b. DATE <b>12/7/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>12-10-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Montrose</b>	23d. LOCATION (City, town, or county) (State) <b>Greenville, Ill.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haeffler</b>			25a. REC'D BY REGISTRAR <b>DEC 13 '61</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur A. Haeffler</b>					

1959

James A. Smith, Esq.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
13785		13761	
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Formerly Cresaptown,</b>	
c. LENGTH OF STAY IN 1b <b>22 years</b>		d. STREET ADDRESS <b>Winchester Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth Mary McKenzie</b>		4. DATE OF DEATH Month Day Year <b>December 28 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-13-91</b>
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Julius Grabenstein</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Marty</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Springfield State Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (b) <b>4-20-61</b> (a), stating the underlying cause last. (c) <b>Schizophrenic reaction, catatonic type.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Schizophrenic reaction, catatonic type.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-25-39</b> , 19 <b>61</b> , to <b>12-28</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>12-28</b> , 19 <b>61</b> , and that death occurred at <b>10:40am</b> the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>12-28-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/2/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		25a. REC'D BY REGISTRAR <b>JAN 2 '62</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

18785

CINCINNATI, OHIO

18785

(M)

February 20, 1878

Blackburn, Wm.

George W. Blackburn

Dear Sir,

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 17th inst.

I have the honor to acknowledge the receipt of your letter of the 17th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,

I am, Sir, very respectfully,

Yours very truly,

Yours very truly,

Wm. Blackburn

Wm. Blackburn

Very respectfully,  
Wm. Blackburn

Wm. Blackburn

Wm. Blackburn

Wm. Blackburn

Wm. Blackburn

Wm. Blackburn

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Wm. Blackburn

Wm. Blackburn

Wm. Blackburn

2

VR AIS (4)  
15M 9/59

## 13786

13762

<b>1. PLACE OF DEATH</b> a. COUNTY <b>CARROLL</b> MARYLAND						<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>						c. LENGTH OF STAY IN lb <b>YEARS</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>36 MAIN ST</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> First Middle Last (Type or print) <b>LIZZIE MAY METCALFE</b>						<b>4. DATE OF DEATH</b> Month Day Year <b>DEC 19 1961</b>					
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>B. DATE OF BIRTH</b> <b>18 Nov. 1873</b>		<b>9. AGE</b> (In years last birthday) <b>88 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER AT HOME</b>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>MARYLAND</b>					
<b>11. BIRTHPLACE</b> (State or foreign country) <b>U.S.</b>						<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>					
<b>13. FATHER'S NAME</b> <b>REUBEN SAYLER</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>MARGARET WRIGHT</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NO NONE</b>						<b>17. INFORMANT</b> Address <b>FRANK METCALFE UNION BRIDGE MD</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Broncho Pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour o. m. p. m. Month Day Year <b>19</b>						<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)						<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from Dec 15, 1961 to Dec 19, 1961, that (I) (we) last saw the deceased alive on Dec 18, 1961, and that death occurred at 5 PM, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <i>J.H. Messler</i>						<b>22b. PHYSICIAN'S NAME (Type)</b> <b>J.H. MESSLER, M.D.</b>					
<b>22c. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						<b>22d. ADDRESS</b> <b>Union Bridge Rd</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL DEC 21-61 PIPE CREEK CEM. CARROLL COUNTY MD</b>						<b>23b. DATE THEREOF</b> <b>DEC 21-61</b>					
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>PIPE CREEK CEM.</b>						<b>23d. LOCATION</b> (City, town, county) (State) <b>CARROLL COUNTY MD</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>D.A. Hutchins</i>						<b>25a. REC'D BY REGISTRAR</b>					
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Caroline E. Hanna</i>						<b>DATE</b> <b>DEC 22 1961</b>					

(M)

2878

CERTIFICATE OF DEATH

2878

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <i>Carroll County</i> <i>Westminster</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Westminster, MD</i> c. LENGTH OF STAY IN 1b <i>70 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Carroll County Gen. Hosp. Westminster, MD</i>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Westminster</i> d. STREET ADDRESS <i>108 Willis St.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																															
3. NAME OF DECEASED (Type or print) <i>Celine Fulton Miller</i>				4. DATE OF DEATH <i>Dec. 21 1941</i>				5. SEX <i>Female</i>				6. COLOR OR RACE <i>W</i>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>Oct 5. 1868</i>				9. AGE (In years last birthday) <i>93 yrs.</i>				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.																											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Helped with housework</i>												10b. KIND OF BUSINESS OR INDUSTRY												11. BIRTHPLACE (Country & State, or foreign country) <i>Walker, Ind. Conn. U. S. A.</i>												12. CITIZEN OF WHAT COUNTRY																							
13. FATHER'S NAME <i>C. Henry Fulton</i>												14. MOTHER'S MAIDEN NAME <i>Harnet Wimbrenner</i>												15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give year or dates of service)												16. SOCIAL SECURITY NO. <i>none</i>												17. INFORMANT <i>Mrs. Harry H. Smith, Westminster, Md.</i> Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arterio-sclerosis</i> DUE TO (c) <i>senility</i>												INTERVAL BETWEEN ONSET AND DEATH <i>12-19-41</i> <i>some years</i> <i>some years</i>																																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no</i>																																															
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																																															
21. I certify that (I) (this hospital) attended the deceased from <i>12-19</i> to <i>12-21</i> , 19 <i>41</i> , that (I) (we) last saw the deceased alive on <i>12-21</i> , 19 <i>41</i> , and that death occurred at <i>1 P.</i> M, from the causes and on the date stated above.																																																											
22a. SIGNATURE <i>E. Billingslea</i> M.D.												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>12-21-41</i>																																															
22c. PHYSICIAN'S NAME (Type) <i>E. L. Billingslea</i>												22d. ADDRESS <i>Westminster, Md.</i>																																															
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>												23b. DATE THEREOF <i>12/23/61</i>												23c. NAME OF CEMETERY OR CREMATORY <i>Westminster Cemetery Westminster, Md.</i>												23d. LOCATION (City, town or county) (State)																							
24. FUNERAL DIRECTOR'S SIGNATURE <i>E. L. Myers, Jr., Westminster, Md.</i>												ADDRESS												25a. REC'D BY REGISTRAR DATE <i>DEC 26 '61</i>												25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>																							



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REPORT OF THE

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13788

13764

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN TB <u>1 yr. 4 mos.</u>				d. STREET ADDRESS <u>1200 Valley Street</u>			
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. NAME OF DECEASED (Type or print) <u>Frances Kalkowsky Miller</u>				4. DATE OF DEATH <u>December 30 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9 1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Packing House</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George Kalkowsky</u>				14. MOTHER'S MAIDEN NAME <u>Catherine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-03-6907</u>			
17. INFORMANT <u>Springfield State Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Senility</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August 8, 1960</u> , to <u>December 30, 1961</u> , that (I) (we) last saw the deceased alive on <u>December 30, 1961</u> , and that death occurred at <u>3 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Agustin Del Campo</u> M.D.				22b. DATE SIGNED <u>December 30 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Agustin Del Campo</u>				22d. ADDRESS <u>Springfield State Hospital Sykesville, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN. 3. 62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>		23d. LOCATION (City, town or county) (State) <u>GERMAN HILL RD MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>DIPPEL BROS</u> ADDRESS <u>1800 E. LOMBARD</u>				25a. REC'D BY REGISTRAR <u>JAN 3 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Robert S. Hanna</u>							

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13789					13765									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>									
c. LENGTH OF STAY IN 1b <b>32yrs., 10mos., 2days</b>					d. STREET ADDRESS <b>1011-2</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ethel Irene Molesworth</b>					4. DATE OF DEATH Month Day Year <b>December 20, 19 61</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>September 17, 1880</b>		9. AGE (In years last birthday) <b>81 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME <b>Ephriam Harris</b>					14. MOTHER'S MAIDEN NAME <b>Ziegler</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service)					16. SOCIAL SECURITY NO. <b>-</b>					17. INFORMANT <b>Springfield Hospital Records.</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary arteriosclerosis, obstructive</b> (c) <b>Heart infarction</b> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Schizophrenic reaction, paranoid type.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Years</b> <b>10-15 days.</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <b>2/18/29</b> , 19... to <b>12/20/61</b> , 19..., that (I) (we) last saw the deceased alive on <b>12/19/61</b> , 19..., and that death occurred at <b>3:45AM</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Agustin del Campo</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/20/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>					22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-23-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>								
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>					25a. REC'D BY REGISTRAR <b>DEC 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

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INVESTIGATION OF DEATH

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13790 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13766														
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>310 S. Main St.</b>					d. STREET ADDRESS <b>310 S. Main St.</b>									
3. NAME OF DECEASED (Type or print) <b>Thomas Oliver Molesworth</b>					4. DATE OF DEATH <b>Dec. 4 19 61</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 22, 1887</b>		9. AGE (In years last birthday) <b>74 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (State or foreign country) <b>Kempton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME <b>John A. Molesworth</b>					14. MOTHER'S MAIDEN NAME <b>Ann Clay</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Mrs Hilda M. Molesworth, Item 2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> <b>Coronary Occlusion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>7m</b>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <b>James T. Marsh</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED				
EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
					Address (Street, city, town, or county)					<b>Carroll 12/4/61</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Dec. 6, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Providence Meth.</b>			22d. LOCATION (City, town, or country) (State) <b>Kempton, Md.</b>						
23. FUNERAL DIRECTOR <b>Olin L. Molesworth</b>					ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>C. Hunt &amp; Sons</b>					

VS. A15ME  
5M 7/59

U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13791						13767					
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>24yrs10mos12dys</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14</b> d. STREET ADDRESS <b>3500 Ailsa Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Zillah Sellers Muhl</b>						4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 6, 1905</b>		9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Edmond Feidler</b>						14. MOTHER'S MAIDEN NAME <b>Bertie Warfield</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, paranoid type.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>  <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>February 1, 1937 to December 13 1961</b>		20g. (County) <b>Dorsey, Howard Co., Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>February 1, 1937</b> to <b>December 13 1961</b> , that (I) (we) last saw the deceased alive on <b>December 12 1961</b> , and that death occurred at <b>4:10AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Agustin del Campo</b> M.D. 22c: PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>						22b. DATE SIGNED <b>12/13/61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-16-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>		23d. LOCATION (City, town or county) (State) <b>Dorsey, Howard Co., Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b> ADDRESS <b>Sykesville, Md.</b>						25a. REC'D BY REGISTRAR <b>DEC 19 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

13791

CONFIDENTIAL

13791



13791

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
13792						13768							
1. PLACE OF DEATH a. COUNTY <i>Carroll</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perryville</i>							
d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Stella Marie MURPHY</i>						4. DATE OF DEATH <i>Dec. 31 1961</i>							
5. SEX <i>F</i>						6. COLOR OR RACE <i>W</i>							
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <i>6-17-1896</i>							
9. AGE (In years last birthday) <i>65</i> yrs.						10. IF UNDER 1 YEAR: Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home cleaning</i>						10b. KIND OF BUSINESS OR INDUSTRY							
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>						12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>John W. Murphy</i>						14. MOTHER'S MAIDEN NAME <i>Florence E. Ryan</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i>—</i>							
17. INFORMANT <i>Hospital Records</i>						Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1 DUE TO</i> Conditions, if any, which gave rise to immediate cause (b) <i>Chronic Degenerative Myocarditis</i> (c) <i>Chronic Brain Syndrome with Carcinoma of the Brain</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome with Carcinoma of the Brain</i>												INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.													
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. (City or town) (County) (State)													
21. I certify that (X) (this hospital) attended the deceased from <i>6-8-54</i> to <i>12-31-1961</i> , that (X) (we) last saw the deceased alive on <i>12-31-1961</i> , and that death occurred at <i>5:45</i> A.M. from the causes and on the date stated above.													
22a. SIGNATURE <i>Konstantin Weber</i> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 12-31-1961													
22c. PHYSICIAN'S NAME (Type) <i>KONSTANTIN WEBER</i> 22d. ADDRESS <i>Oak St., Sykesville, Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>													
23b. DATE THEREOF <i>1-2-1962</i>													
23c. NAME OF CEMETERY OR CREMATORY <i>Asbury Cemetery</i>													
23d. LOCATION (City, town or county) (State) <i>Port Deposit, Md. Rural</i>													
24. FUNERAL DIRECTOR'S SIGNATURE <i>La. A. Lathum &amp; Son, Perryville, Md.</i>													
25a. REC'D BY REGISTRAR <i>—</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>													
DATE <i>JAN 3 '62</i>													

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THE STATE OF TEXAS

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VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13794

CERTIFICATE OF DEATH

13770

1. PLACE OF DEATH a. COUNTY <b>CARROLL CO.</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - WESTMINSTER</b> c. LENGTH OF STAY IN 1b <b>69 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SMALLWOOD ROAD</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - WESTMINSTER MD.</b> d. STREET ADDRESS <b>RT #6 WESTMINSTER</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM HOWARD NINER</b>				4. DATE OF DEATH <b>DEC. 26 19 61</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 19, 1892</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CARROLL CO. MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOSEPH NINER</b>				14. MOTHER'S MAIDEN NAME <b>HANNAH LOGUE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>212-24-6228</b>		17. INFORMANT <b>HOWARD NINER - RD #5 WESTMINSTER</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>viral pneumonia</b> <b>480X</b> DUE TO (b) <b>influenza</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>about 3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pleural effusion, chimosis of liver</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>april 19 61</b> to <b>Dec 26 19 61</b> that (I) (we) last saw the deceased alive on <b>Dec 18 19 61</b> and that death occurred at <b>3A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>E. Reese Wilkens</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec 28</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. Reese Wilkens</b>				22d. ADDRESS <b>15 Kemper ave westminster md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/29/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DEER PARK CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>SMALLWOOD MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James G. Saffell - Westminster Md</b>				ADDRESS <b>Westminster Md</b>		25a. REC'D BY REGISTRAR <b>DEC 29 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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General Officer, Air Force, London

11 Dec 41

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10 Dec 41

General Officer, Air Force, London

E. House, W. Kensington

General Officer, Air Force, London

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

13795

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13771

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>13yrs.5mos.5days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>908 St. George's Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rochester</b> Middle Last <b>Ober</b>		4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 14, 1919</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- None</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank B. Ober</b>		14. MOTHER'S MAIDEN NAME <b>Margaret DelRochester</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Large multiple infected decubitus ulcers</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental deficiency without psychosis, imbecile level.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Weeks</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 28, 1961</b> to <b>December 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>December 3, 1961</b> , and that death occurred at <b>11:20 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE <b>12/3/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12-4-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>W. J. Lee</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>		25. REC'D BY REGISTRAR DATE <b>DEC 6 '61</b>	
ADDRESS <b>Sykesville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur H. Haight</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
13796									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>2 yrs./19 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore #11</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3828 Tudor Arms Ave.</b> d. STREET ADDRESS <b>3828 Tudor Arms Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Walter</b> First <b>George, Jr.</b> Middle <b>ODELL</b> Last <b>ODELL</b>					4. DATE OF DEATH Month <b>12</b> Day <b>- 2</b> Year <b>, 19 61</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-6-1879</b>		9. AGE (In years last birthday) <b>82</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Theatrical stage hand</b>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Walter Odell, Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Charlotte Doubleday</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>214-03-5496</b>		17. INFORMANT <b>Springfield State Hospital Records</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure due to rheumatic heart disease</b> <b>410X</b> DUE TO (b) <b>and mitral valve insufficiency.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>qualifying phrase,</b> <b>Hematoma left scalp. CBS with cerebral arteriosclerosis without</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/2/61</b> Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-5-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Church</b>		22d. LOCATION (City, town, or country) (State) <b>Kingsville, Maryland</b>			
23. FUNERAL DIRECTOR <b>John O. Mitchell &amp; Sons, Inc.</b> ADDRESS <b>1900 Eutaw</b>					24a. REC'D BY REGISTRAR <b>Pl. DEC 5 '61</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>		

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FOR STATE  
HEALTH DEPT

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13773

13797

1. PLACE OF DEATH a. COUNTY <b>M Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminister</b> c. LENGTH OF STAY in 1b <b>39 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RT4 - TANNERY ROAD</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Carroll</b> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminister</b> h. STREET ADDRESS <b>RT4. TANNERY ROAD.</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THURMAN THOMAS PETRY</b>		4. DATE OF DEATH Month <b>12</b> Day <b>4</b> Year <b>1961</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 5, 1922</b>	9. AGE (In years last birthday) <b>39 yrs.</b>	IF UNDER 1 YEAR Months <b>39</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JUNKMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCRAP METAL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM O. PETRY</b>			14. MOTHER'S MAIDEN NAME <b>GERTRUDE KINGLING</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW II 213-14-4482</b>		17. INFORMANT <b>STATE POLICE.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of skull</b> <b>823X</b> <b>XXXXX</b> <b>Fracture of neck</b> Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of right femur</b> (a), stating the underlying cause last. (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Was driver of car that ran off the road and struck culvert abutment.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was driver of car that ran off the road and struck culvert abutment.</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:50</b> <b>12-4</b> <b>1961</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Westminister Carroll Maryland</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12-4-61</b>			
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/7/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER CEM.</b>			
22d. LOCATION (City, town, or country) (State) <b>WESTMINSTER MD.</b>							
23. FUNERAL DIRECTOR <b>James E. Saffell, Westminister, Md.</b>		4a. REC'D BY REGISTRAR <b>DEC 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

MEDICAL CERTIFICATION

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13798

## CERTIFICATE OF DEATH

Reg. Dist. No. 13774

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X R. D. 1, Finksburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pullen Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Estella</u> Middle <u>Powers</u> Last <u>s</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>? Powers</u>		14. MOTHER'S MAIDEN NAME <u>? ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Pullen Nursing Home, Sykesville, Md.</u>	
17. INFORMANT <u>Pullen Nursing Home, Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (terminal)</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemiplegia</u> DUE TO (c) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 mos</u> <u>3 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Large decubitus ulcers</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10:20</u> 19 <u>61</u> , to <u>12:18</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>12-18</u> , 19 <u>61</u> , and that death occurred at <u>7:00</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sani Okutman</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Sykesville, Md. 12-18-61</u>	
PHYSICIAN'S NAME (Type) <u>Sani Okutman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-20-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz, Winfield, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 22 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

NAME OF DECEASED _____		SEX _____	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
TIME OF DEATH _____		PLACE OF INTERMENT _____	
NAME OF PHYSICIAN _____		NAME OF FUNERAL HOME _____	
NAME OF WITNESS _____		NAME OF REGISTRAR _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	
DATE _____		TIME _____	

This certificate is to be filled out by the physician or the registrar, and is to be filed in the office of the Registrar of Deaths, Baltimore, Maryland. It is to be used for the purpose of recording the death of a person, and for the purpose of determining the cause of death. It is to be filled out in duplicate, and the original is to be filed in the office of the Registrar of Deaths, Baltimore, Maryland. The duplicate is to be sent to the office of the State Department of Health, Baltimore, Maryland.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13799  
CERTIFICATE OF DEATH  
13775

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3011 Northway Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Christina First Duvall Middle Raymond Last		4. DATE OF DEATH Month 12 Day 30 Year 19 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-27-84
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Luther Duvall		14. MOTHER'S MAIDEN NAME Christina Stuart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 213285065	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular Disease (c) CBS with Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH minutes years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-9 to 12-30 1961, that (I) (we) last saw the deceased alive on 12-29 1961, and that death occurred at 5 AM, from the causes and on the date stated above.			
22a. SIGNATURE Rita S. Glahn M.D.		22b. DATE SIGNED 12-30-61	
22c. PHYSICIAN'S NAME (Type) Rita S. Glahn		22d. ADDRESS Springfield State Hosp.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/3/62	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE		23d. LOCATION (City, town or county) BALTIMORE MD (State)	
24. FUNERAL DIRECTOR'S SIGNATURE L. J. Ruck		24b. ADDRESS 5305 HARFORD Rd.	
25a. REC'D BY REGISTRAR JAN 4 '62		25b. REGISTRAR'S SIGNATURE Christina S. Glahn	

1941

STATE OF TEXAS

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THE STATE OF TEXAS, COUNTY OF DALLAS, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County Clerk of said County.

Witness my hand and the seal of said County, this 1st day of January, 1941.

County Clerk

Attest:

Notary Public

My Comm. Expires



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13800

13776

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>23 days</u> <u>6 yrs. / 7 mons.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3401-4</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore #1</u> d. STREET ADDRESS <u>851 Eutaw St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>Patrick</u> Last <u>RYAN</u>				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>16</u> Year <u>1961</u>									
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3-4-12</u>		<b>9. AGE</b> (In years last birthday) <u>49 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>7</u>		<b>IF UNDER 24 HRS.</b> Hours <u>7</u> Min. <u>7</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John J. Ryan</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Oelia</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>-</u>				<b>17. INFORMANT</b> Address <u>Springfield State Hospital Records</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO (b) <u>Abscess formation due to terminal phase of</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>tongue (primary) malignancy with metastatic</u> (c) <u>legions of throat and neck.</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>7</u> Days <u>7</u> Weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS assoc. with Alcohol Intoxication with Psychotic reaction.</u>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>4/19/55</u> to <u>12/16/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/16/61</u> , 19 <u>61</u> , and that death occurred at <u>5:20 p.m.</u> from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>Agustin del Campo</u> M.D.						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12/16/61</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Agustin del Campo, M.D.</u>						<b>22d. ADDRESS</b> <u>Sykesville, Maryland</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>12/20/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Cathedral</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Falto. Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Water Dubrowski was Dunack Ave.</u>						<b>ADDRESS</b>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 19 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>James J. Thomas</u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>360 Main Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll County General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDNA</u> First Middle Last		4. DATE OF DEATH <u>December 1</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 23 1889</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonida A. Lusby</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte V. Schoolding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mr. Frank Savage</u> Address <u>Reisterstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Thrombosis acute</u> DUE TO <u>420</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO <u>6 months</u> (c) <u>Pneumonia</u> DUE TO <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1961</u> to <u>December 1961</u> , that (I) <u>(the)</u> last saw the deceased alive on <u>December 1 1961</u> , and that death occurred at <u>7:19 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>CLARENCE E. McWilliams</u>		22b. ADDRESS <u>11904 Reisterstown Rd. Reisterstown Maryland</u>	
22c. PHYSICIAN'S NAME (Type)		22d. DATE <u>December 1 1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/4/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>All Saints Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Reisterstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry James Eckhardt Owings Mills Md</u>		25a. REC'D BY REGISTRAR <u>DEC 4 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

MEDICAL CERTIFICATION

(M)

19801

THE HOUSE OF DEATH

19801 A. 19801

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>17 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore #17</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3 V01-4</b> d. STREET ADDRESS <b>1715 N. Payson St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Reba</b> Last <b>SCHEIN</b>						4. DATE OF DEATH Month <b>12</b> Day <b>-</b> Year <b>1961</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 1895</b>		9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital helper</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Maurice Horwitz</b>						14. MOTHER'S MAIDEN NAME <b>Esther Vinnick</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield State Hospital, Sykesville, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pulmonary artery embolism due to</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>probably embolism due to infected decubitus ulcers.</b> days DUE TO (c) <b>Heart failure due to rheumatic heart disease.</b> days/years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic Depressive psychosis, manic phase.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>5-15-66</b> to <b>12-2-61</b> , that (I) (we) last saw the deceased alive on <b>12-2-61</b> , and that death occurred at <b>4:20 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Agustin del Campo</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>12-2-61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>						22d. ADDRESS <b>Sykesville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shaarei Tefeloh</b>		23d. LOCATION (City, town or county) (State) <b>Balto Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc</b> ADDRESS <b>2100 Eutan Place</b>						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <b>Richard S. Kenna</b>		
						DATE <b>DEC 5 '61</b>					

30261

M



13803

## CERTIFICATE OF DEATH

Reg. Dist. No. 13779

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WINDYBINE</u>		c. LENGTH OF STAY IN 1b <u>3 YRS. 4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weitzel's Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HANNAH</u> Middle <u>SCHILLING</u> Last <u>-</u>		4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/23/1875</u>
9. AGE (In years last birthday) yrs. <u>86</u>		10. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Conway</u>		14. MOTHER'S MAIDEN NAME <u>MARY (LAST NAME UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Edward M. Schilling</u>		18. ADDRESS <u>same</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, arteriosclerosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Heart disease, arteriosclerosis generalized.</u> DUE TO (c) <u>Blood vessel disease -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1960</u> <u>70</u> <u>29 Dec 61</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) (County) (State) <u>-</u>

21. I certify that I attended the deceased from <u>960</u> , 19 <u>60</u> , to <u>29 Dec</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>29 Dec</u> , 19 <u>61</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.		DATE SIGNED <u>29 Dec 61</u>
ACTUAL SIGNATURE <u>Howard E. Lee</u> M.D. <u>Aggraville, Md</u>		ADDRESS (Street, city or town, state) <u>Aggraville, Md</u>
PHYSICIAN'S NAME (Type) <u>-</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/2/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck</u>		24a. REC'D BY REGISTRAR <u>1 JAN 2 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>James L. Thomas</u>		24c. ADDRESS <u>5305 HARFORD Rd.</u>	

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VS A15 (4)  
15M 9/58

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRAL OFFICE

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TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AT5 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13804

13780

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middleburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont rural</b>	
c. LENGTH OF STAY IN 1b <b>4 weeks</b>		d. STREET ADDRESS <b>Brookfield Manor Nursing Home</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Brookfield Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Arthur</b> Last <b>Seiss</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>20</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 31, 1876</b>
9. AGE (In years, last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>85</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farms</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Seiss</b>		14. MOTHER'S MAIDEN NAME <b>Mary McGrath</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-0799</b>	
17. INFORMANT <b>Cloyd W. Seiss</b>		Address <b>Emmitsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>450.0</b> DUE TO (c) <b>450.0</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/30/61</b> 19____, to <b>12/20/61</b> 19____, that (I) (we) last saw the deceased alive on <b>12/19/61</b> 19____, and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. H. Caricofe</b>		22b. DATE SIGNED <b>12/20/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. H. CARICOFE</b>		22d. ADDRESS <b>Union Bridge, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-23-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Thurmont, Md. Fred. Co.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Guay</b>		ADDRESS <b>Thurmont, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

# CERTIFICATE OF DEATH

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DECEASED

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CHIEF CLERK

REGISTRATION

DEPARTMENT

OF HEALTH

STATE OF

NEW YORK

1930

1930

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13805

## CERTIFICATE OF DEATH

Reg. Dist. No. 13781

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>12 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Co. General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>A.</u> Last <u>Shaffer</u>		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1911</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>50</u> Days <u>18</u> Hours <u>11</u> Min.	11. IF UNDER 24 HRS. Months <u>50</u> Days <u>18</u> Hours <u>11</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Newman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-3209</u>	
17. INFORMANT <u>Mrs David A. Shaffer, Westminster Md Rd 4</u>		Address <u>Westminster Md Rd 4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the <u>under-</u> lying cause lost. (c) <u>Coronary Sclerosis</u> 3-4410 INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 27</u> , 19 <u>61</u> , to <u>Dec 30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 30</u> , 19 <u>61</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>12/30/61</u> ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D. PHYSICIAN'S NAME (Type) <u>W. GLENN SPEICHER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/3/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural, Westminster, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>		24a. RECEIVED BY REGISTRAR DATE <u>JAN 3 1962</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

13202

CENTRAL CHURCH

WARRANT STATE OF NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13806

CERTIFICATE OF DEATH

13782

Item 14 Film G304 1/2/62 jwk

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 19 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14</b>		3 VOI-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>4606 Harford Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>P.</b> Last <b>Soellers</b>				4. DATE OF DEATH Month <b>December</b> Day <b>21</b> , Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-25-1874</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>August Soellers</b>				14. MOTHER'S MAIDEN NAME <b>Caroline - unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>218-10-1114</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase.</b>						INTERVAL BETWEEN ONSET AND DEATH Days <b>4-20-1</b> Years <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 2, 1961</b> to <b>December 21, 1961</b> that (I) (we) last saw the deceased alive on <b>December 20, 1961</b> , and that death occurred <b>4:20 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/21/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/26/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. J. Ruck</b>				ADDRESS <b>5305 HARFORD Rd.</b>		25a. REC'D BY REGISTRAR <b>DEC 26 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Rimes</b>			

13806

13806

CENTRAL ON STATE

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
MEMORANDUM  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[The remainder of the document contains several paragraphs of text that are mostly illegible due to the quality of the scan. Some words like "New York", "Bureau", and "subject" are faintly visible.]

1  
FOR STATE  
HEALTH DEPT.

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VS. A15ME  
5M 7/59

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MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY City			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2yrs. 5mos. 8dys.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 30			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 1302 Towson Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Francis Odell Stare				4. DATE OF DEATH December 28 1961				5. SEX Female			
6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH July 10, 1904			
9. AGE (In years last birthday) 57 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles Campbell				14. MOTHER'S MAIDEN NAME Emma Harford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -				17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO (b) CENTRAL NERVOUS SYSTEM SYPHILIS DUE TO (c) Schizophrenic Reaction, Paranoid type. Systemic Syphilis (Arrested general paresis cannot be ruled out). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH YEARS.							
20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER JAMES T MARSH M.D. DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) Carron 12/28/64				DATE SIGNED			
22a. BURIAL CREMATION REMOVAL (Specify)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY			
22d. LOCATION (City, town, or country) (State)				22e. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
23. FUNERAL DIRECTOR Frank H Newell				24a. ADDRESS				DATE JAN 5 '62			



## CERTIFICATE OF DEATH

Reg. Dist. No. 13783

13808

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>50 years +</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster 27</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jordan's Rest Home</u>				d. STREET ADDRESS <u>155 W. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) <u>IOWA CECILIA STARNER</u> First Middle Last				4. DATE OF DEATH <u>DEC. 16 1961</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 15 1875</u> 86 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David R. Petry</u>				14. MOTHER'S MAIDEN NAME <u>Sarah H. Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u> INFORMANT <u>Mrs. Ralph D. Starnes, Westminster, Md.</u> Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DIS</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 26</u> , 19 <u>58</u> , to <u>DEC 16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>DEC 15</u> , 19 <u>61</u> , and that death occurred at <u>8:10</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>14 RIDGE ROAD</u> DATE SIGNED <u>12/16/61</u> ACTUAL SIGNATURE <u>David I Welliver</u> M.D. <u>DANIEL I WELLIVER</u> WESTMINSTER MARYLAND PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/20/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burnt Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural, Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>				ADDRESS <u>Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 22 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>John S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

141

13003

OFFICE OF DEATH

DEC 12 1961  
D. B. SWANSON  
116 DEER ROAD  
TWIN LAKE, ILLINOIS 62558  
MRS. SWANSON



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13809

13784

1. PLACE OF DEATH e. COUNTY <b>Carroll</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>47 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>1718 Linden Ave.</b>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Josephine B. Stone</b>			4. DATE OF DEATH <b>December 9 19 61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1868</b>		9. AGE (in years if under 1 year, last birthday) <b>93 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milliner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Milliner</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Maryland</b>	
13. FATHER'S NAME <b>Carlos Bouchet</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Springfield State Hospital Sykesville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency (Decompensation)</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic depressive reaction.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Sykesville</b>		20g. (County) <b>Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>July 7, 1914</b> , to <b>December 9, 1961</b> that (I) (we) last saw the deceased alive on <b>Dec. 9, 1961</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Naci N. Buyukunsal, M.D.</b>		22b. DATE SIGNED <b>Dec. 9, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M.D.</b>	
22d. ADDRESS <b>Sykesville, Maryland</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Travis Ridge</b>	
23d. LOCATION (City, town or county) <b>Pikesville, Md.</b>		23e. (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>		24a. ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haight</b>		25c. DATE <b>DEC 19 61</b>			

1881

CERTIFICATE OF DEATH

1880

DEPARTMENT OF HEALTH  
BUREAU OF STATISTICS  
CITY OF NEW YORK  
OFFICE OF THE REGISTRAR  
DEATH CERTIFICATE  
No. 1000  
Name of Deceased  
Age  
Sex  
Color  
Date of Death  
Place of Death  
Cause of Death  
Signature of Registrar  
Signature of Physician  
Signature of Coroner

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 305  
1-12-62  
13810  
13785

18&21 Film 305  
1-12-62  
13810  
13785

1. PLACE OF DEATH  
a. COUNTY **Carroll** MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Silver Run**  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Fair's Inn**

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)  
a. STATE **Maryland** b. COUNTY **Carroll**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Westminster**  
d. STREET ADDRESS **Rt. 4** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **CLETUS HARRY STONESIFER**  
4. DATE OF DEATH **December 31 19 61**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **Jan. 30, 1919** 9. AGE (In years last birthday) **42** yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Farm Hand** 10b. KIND OF BUSINESS OR INDUSTRY **Farming** 11. BIRTHPLACE (State or foreign country) **Carroll Co., Md.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Harry Stonesifer** 14. MOTHER'S MAIDEN NAME **Gertie Stonesifer**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **216-16-1935** 17. INFORMANT **Mrs. Gertie Stonesifer, Westminster, Md. R-4** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Ethyl Alcohol Intoxication**  
**322.2** DUE TO  
Conditions, if any, which gave rise to immediate cause (b)   
(e), stating the underlying cause last. } DUE TO (c)   
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH. ☐ 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐  
ACTUAL SIGNATURE **Charles S. Petty** M.D. ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **12/31/61**  
EXAMINER'S NAME (Type) **Charles S. Petty, M.D.** DEPUTY MEDICAL EXAMINER ☐  
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **1/2/1962** 22c. NAME OF CEMETERY OR CREMATORY **Bachmans Valley Cemetery** 22d. LOCATION (City, town, or country) (State) **Nr. Westminster, Carroll Co. Md.**

23. FUNERAL DIRECTOR ADDRESS **Richard A. Little, Littlestown, Pa.** 24a. REC'D BY REGISTRAR **2 '62** 24b. REGISTRAR'S SIGNATURE **Richard S. Haus**

THE STATE  
OF NEW YORK

(M)

(1)

1913

March

10th day

of April

1913

1913

and hand

the following

the following

the following

X

X

X

1913

George A. Felt, D.D.

George A. Felt, D.D.

George A. Felt, D.D.

George A. Felt, D.D.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13811

## CERTIFICATE OF DEATH

13786

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution, address before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Harford</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b> d. STREET ADDRESS <b>Route 7 Box 23</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clyde Vernon Tibbs</b>			4. DATE OF DEATH Month Day Year <b>December 23 1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-9-1896</b>	9. AGE (in years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer - Shipyard work</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>John Tibbs</b>			14. MOTHER'S MAIDEN NAME <b>Unknown Belle Cox</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>217-16-3459</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease.</b> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS due to arteriosclerosis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-20-1961</b> to <b>12-23-1961</b> that (I) (we) last saw the deceased alive on <b>12-23-1961</b> and that death occurred at <b>12:30pm</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>12/23/61</b>
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 27, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City, town or county) <b>Bel Air, Harford, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McComas &amp; Son</b>		ADDRESS <b>Abingdon Maryland.</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 27 61</b>
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

11251



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13812

13787

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1 mo. 7 days		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		d. STREET ADDRESS 704 E. Goldspring Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Boyd Bowman Tweddle		4. DATE OF DEATH 12/31/		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/7/ 1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-GE		10b. KIND OF BUSINESS OR INDUSTRY G.E.		11. BIRTHPLACE (County & State, or foreign country) Baltimore City Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Tweddle		14. MOTHER'S MAIDEN NAME Jennie ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Springfield Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial infarction Pneumonia, Left lower lobe Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Dec. 29, 1961 to Dec. 31, 1961 that (I) (we) last saw the deceased alive on December 31, 1961, and that death occurred at 11:30am, from the causes and on the date stated above.																	
22a. SIGNATURE Agustine del Campo. M.D.												22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)												22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-3-1962		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town or county) Baltimore, Maryland		23e. REC'D BY REGISTRAR JAN 3 '62		23f. REGISTRAR'S SIGNATURE Arthur L. Thomas							
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.																	

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JOE YORK  
1-2-1965

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13813

13788

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5yrs. 2mos.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 11</b> d. STREET ADDRESS <b>Parkdale &amp; Girard Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Irving</b> First <b>Lawrence</b> Middle <b>Twilley</b> Last		4. DATE OF DEATH Month <b>December</b> Day <b>15,</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant Marine</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipping -</b>	9. AGE (In years last birthday) <b>60 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Irving L. Twilley</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Cassard Murphy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-2130</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4-22-1</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with central nervous system syphilis with psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 15, 1956</b> , to <b>December 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>December 14, 1961</b> , and that death occurred at <b>6 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b> M.D.		22b. DATE SIGNED <b>12/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-18-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b> ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur H. Haight</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13814

Item 2 Film G304 1/4/62 1wk

13789

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> <b>MARYLAND</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b>		c. LENGTH OF STAY IN 1b <b>19y 7wks 29da</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSPT. SYKESVILLE, MD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MICHELINA VENTIMIGLIA</b>		4. DATE OF DEATH <b>December 23 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-II-76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>ITALY</b>
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>029X</b> DUE TO <b>CEREBRAL ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>plus SYSTEMIC SYPHILIS</b> (c) <b>PSYCHOSIS DUE TO ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>20 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-24-1942</b> to <b>12-23-1961</b> , that (I) (we) lost saw the deceased alive on <b>12-23-1961</b> , and that death occurred at <b>1:55 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Ilse Kamm</b>		22b. DATE SIGNED <b>12/23/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. ILSE KAMM</b>		22d. ADDRESS <b>SPRINGFIELD STATE HOSPT.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/29/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, Inc. 715 Light St. -30</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 29 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

1878

NEW YORK

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## CERTIFICATE OF DEATH

Reg. Dist. No. 13790

13815

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>31 Frederick St. Rear</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Jacob</b> Last <b>Wantz</b>		4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/28/1895</b>
9. AGE (In years last birthday) <b>66</b>		10. IF UNDER 1 YEAR: Months <b>1</b> Days <b>12</b> Hours <b>40</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Blacksmith Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harvey Wantz</b>		14. MOTHER'S MAIDEN NAME <b>Flora Zahn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-32-1117</b>	
17. INFORMANT <b>Mrs. Mabel Wantz, 31 Frederick St., Rear</b>		Address <b>Taneytown, Md.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>12</b> Day <b>19</b> Year <b>1961</b> Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-2</b> 19 <b>57</b> , to <b>Dec. 22</b> 19 <b>61</b> , that I last saw the deceased alive on <b>Dec 19</b> 19 <b>61</b> , and that death occurred at <b>8:50</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James J. Marsh</b>		ADDRESS (Street, city or town, state) <b>105 E. MAIN ST</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>		DATE SIGNED <b>12-22-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/24/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pleasant Valley, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		ADDRESS <b>Littlestown, Pa.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kramo</b>	

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 13791

13816

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>				c. LENGTH OF STAY IN 1b <i>73 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>CHARLES HARRY</i> First Middle Last <i>Weer</i>				4. DATE OF DEATH Month <i>Dec.</i> Day <i>11</i> Year <i>1961</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 27, 1884</i>	9. AGE (In years last birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Funeral Director</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Funeral</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James R. Weer Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Ruth M. Sucker</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-14-7698A</i>		INFORMANT Address <i>Mr. Millard H. Weer - Sykesville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery, Coronary Thrombosis, 420.1</i> DUE TO <i>Ischemic heart disease, Enteroceleum</i> DUE TO <i>Generalized - abd. aneurysm</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>1954 to 1961</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>1954</i> , 19, to <i>1961</i> , 19, that I last saw the deceased alive on <i>Dec 61</i> , 19, and that death occurred at <i>8:00</i> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Howard E. Hall</i>		M.D. <i>Sykesville, Md.</i>		ADDRESS (Street, city or town, state) <i>Sykesville, Md.</i>		DATE SIGNED <i>13 Dec 61</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		SYKESVILLE, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-14-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Springfield</i>		22d. LOCATION (City, town, or county) <i>Sykesville Carroll Co. Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>		ADDRESS <i>Sykesville, Md.</i>		24a. REC'D BY REGISTRAR <i>DEC 19 61</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Fennell</i>	

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